The Changing Face of Health Care Reform

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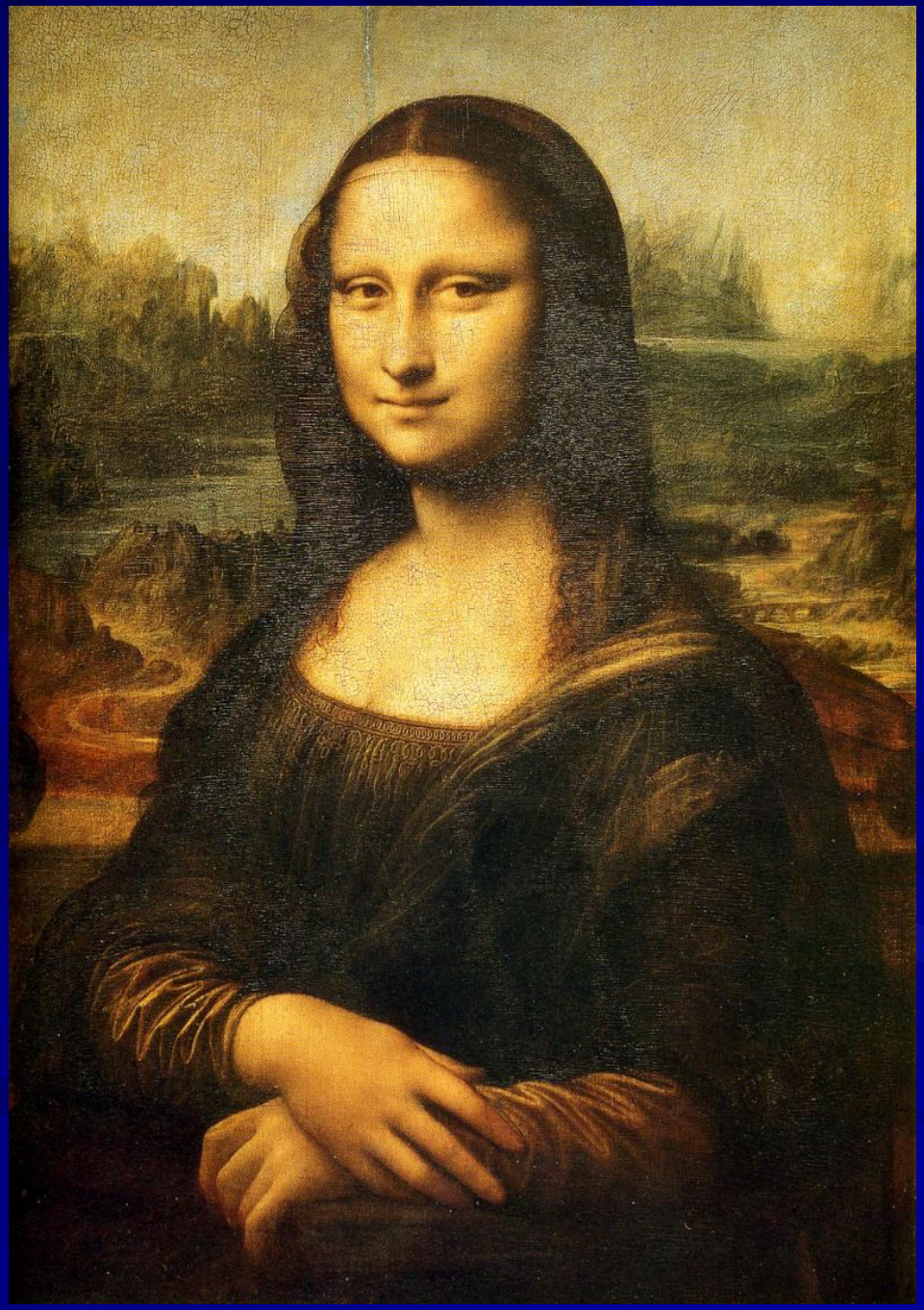


Health Care Reform Challenges: What Are the Key Questions?

- **Is near universal coverage a key goal?**
- **Do individuals (including employees) have a choice of plans?**
  - If so, do they have better ways to comparison shop?
  - If so, are there ways to address adverse selection?
- **What is the responsibility of the individual?**
  - Maintain insurance – but only at higher incomes?
  - Maintain insurance at all incomes, if individual's costs are "affordable"
- **What are the responsibilities of the employer?**
  - Play or pay?
  - Choose coverage or provide defined contribution?
  - The challenge of ERISA
- **What are the responsibilities of government?**
  - Deliver health care?
  - Fund the delivery of health care to all?
  - Support those most in need
- **Does the proposal have any meaningful ways to control costs and improve value?**

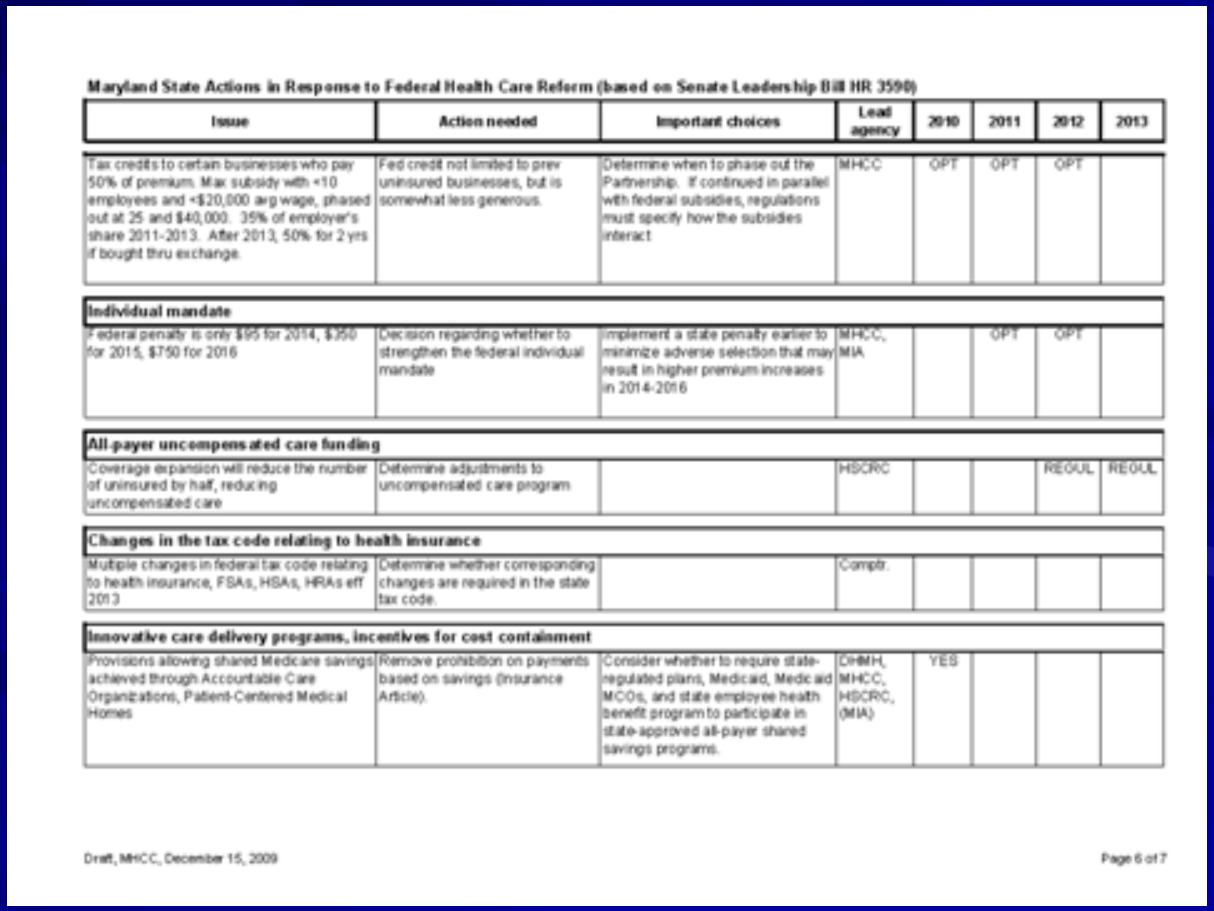
Reform Strategies Are Interdependent

- No pre-ex, no underwriting => Viable insurance pool
- Viable insurance pool => broad participation, including young and healthy
- Broad participation => individual mandate, employer participation
- Broad participation => penalties for free-riding
- Individual mandate and penalties => affordable plan
- Affordable plan => low income subsidies
- Affordable plan => narrower benefits or shallower benefits, new incentives
- Affordable plan => real, sustained attention to controlling costs and rewarding true value

- Individual choice, including employee choice => individual plans, merger of the individual and small group markets
- Portability => individual plans, merger of the individual and small group markets
- Individual choice and individual plans => exchange with risk adjustment

Maryland Health Care Reform Coordinating Council:

- Established by Governor O'Malley
- Chaired by Lt. Gov. Brown and Sec. Colmers
- Multi-agency collaboration to identify state actions
- Mechanism to get broad input into key policy decisions



Maryland State Actions in Response to Federal Health Care Reform (based on Senate Leadership Bill HR 3590)

Issue	Action needed	Important choices	Lead agency	2010	2011	2012	2013
Tax credits to certain businesses who pay 50% of premium. Max subsidy with <10 employees and <$20,000 avg wage, phased out at 25 and $40,000. 35% of employer's share 2011-2013. After 2013, 50% for 2 yrs if bought thru exchange.	Fed credit not limited to prev uninsured businesses, but is somewhat less generous.	Determine when to phase out the Partnership. If continued in parallel with federal subsidies, regulations must specify how the subsidies interact	MHCC	OPT	OPT	OPT	
Individual mandate							
Federal penalty is only $95 for 2014, $350 for 2015, $750 for 2016	Decision regarding whether to strengthen the federal individual mandate	Implement a state penalty earlier to minimize adverse selection that may result in higher premium increases in 2014-2016	MHCC, MIA		OPT	OPT	
All-payer uncompensated care funding							
Coverage expansion will reduce the number of uninsured by half, reducing uncompensated care	Determine adjustments to uncompensated care program		HSCRC			REGUL	REGUL
Changes in the tax code relating to health insurance							
Multiple changes in federal tax code relating to health insurance, FSAs, HSAs, HRAs eff 2013	Determine whether corresponding changes are required in the state tax code.		Comptr.				
Innovative care delivery programs, incentives for cost containment							
Provisions allowing shared Medicare savings achieved through Accountable Care Organizations, Patient-Centered Medical Homes	Remove prohibition on payments based on savings (Insurance Article).	Consider whether to require state-regulated plans, Medicaid, Medicaid MCOs, and state employee health benefit program to participate in state-approved all-payer shared savings programs.	DHMH, MHCC, HSCRC, (MIA)	YES			

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State Insurance Market Reforms: Key Design Issues

- Givens:
  - guaranteed issue and renewal, no pre-ex, limits on rescission
  - modified community rating
- What rating variations based on age (and other non-health factors) will be allowed in individual / SGM ?
  - Implications of low and high ratios
- Should the individual and small group markets be merged?
  - Advantages: portability of coverage, employee choice, broader risk pool, global risk adjustment across the pool, simplified administration
  - Other implications: premiums will vary by age in employer-sponsored plans as well, employers contribute a percentage of the premium
    - A wash for the employer, but implications for young and old employees depending on employee share of premium

State Insurance Market Reforms: Key Design Issues

- Risk selection and "parallel markets" outside the exchange
  - Law requires consumer choice – plans may be offered outside the exchange
  - Law requires carriers to offer the same plans at the same price inside and outside the exchange
    - Will the price be with or without commissions to producers?
    - Exchanges must contract with "Navigators" for advertise, inform, enroll
    - Navigators may not be paid by a carrier – payment or commission from exchange
  - Law requires a single risk pool for a carrier's products in a market
  - Law establishes provisions for risk-adjusted payments to plans based on risk selection
  - Risk selection through plan design and marketing is decreased to some degree by federal structuring of health benefits
    - Essential benefit package (breadth of covered services)
    - Standardized format for description of benefits
    - Standard nomenclature for cost-sharing based on actuarial value (bronze, etc…)
    - Rating of quality and value of plans, enrollee satisfaction

State Implementation of a Health Insurance Exchange:

- 2010: Assist individuals and small employers in finding affordable health insurance through a web site
  - Federal web site in two stages:
    - general carrier and plan benefit information (July)
    - extensive information about benefits, premiums for most individual and SGM plans
  - Provide information about state subsidy, federal tax credit
- 2011 or 2012: Legislation reforming individual and small group markets effective 2014, establishing the exchange structure, functions, and governance
  - Design of the exchange will depend on state decisions about the individual and small group markets
  - Governmental or quasi-independent agency oversight is assumed
  - Actual implementation could be done by the state or through contract with one or more third-party administrators
- January 1, 2014: Medicaid expansion, insurance market reforms, exchange

The State Exchange: Key Design Issues

- Scope:
  - Is the exchange primarily a method to get subsidized coverage?
  - Or is it a primary way to structure the individual and small group markets for greater transparency and efficiency, potentially lower costs?
- Functions:
  - Provide information to guide choice
  - Refer to brokers/carriers – or accept standardized application for coverage on behalf of carriers?
  - Perform billing of individuals and employers like a TPA, or does billing remain a carrier function?
  - Actively design benefits, select plans that may be offered
  - Actively negotiate prices with carriers

Other issues requiring early consideration:

- Authorize MHIP to administer the federal high risk pool for the state
  - Federal provisions differ from current MHIP provisions
- Consider how the Partnership subsidy for small low-wage businesses interacts with the new federal tax credits to small businesses
  - Federal provisions differ substantially from current Partnership provisions
- Consider changes to Maryland law needed for payment reform pilot programs (PCMH, ACO, other acronyms)
  - Allow provider payments that are based in part on efficiency
  - Shared savings strategies

Three Select Concerns About the PPACA:

- The cost
  - Savings rely on substantial reductions in Medicare spending
  - Medicare savings will probably lead to cost shifting
  - Cost shifting poses special problems in Maryland
- Adverse selection into the individual and small group markets, followed by rising premiums, due to:
  - The relatively weak penalties enforcing the individual mandate
  - Sudden infusion of high risk pool participants (and an end to the subsidization of HRPs that have kept individual market premiums artificially low)
  - The ability of businesses with 50-100 employees to choose the exchange or self-insurance with stop-loss

  This price increase will be mitigated somewhat by reinsurance during transition.
- A continuing reluctance to deal straightforwardly with cost drivers and difficult choices.

Health Insurance Industry Has Not Fared Well in this Debate

- A public plan is needed to keep the insurers honest.
- The reforms will end abusive and unfair practices of health plans.
- The reforms will end discrimination by health insurers against the sick.
- New resources to states to rein in price gouging by insurance companies
  - SEC. 104. SUNSHINE ON PRICE GOUGING BY HEALTH INSURANCE ISSUERS.
- Exclude insurers who put profits over patients

What Seems to be Going On Here?

- Unavoidable (and partially understandable) demonization
- Residual backlash - anger about clumsy managed care
  - Health plans were generally doing what purchasers wanted, reducing health care costs in the only ways readily available: driving down provider reimbursements and saying "no"
  - Two lessons: 1) it's dangerous to get between the doctor and the patient – at least one of them has to buy in 2) "no" must be both more understandable and more subtle
- Mystification about the 20-40% of premium going toward administration rather than care – where is the value in that?
- Understandable bewilderment and anger about health care costs
  - Health plans have largely failed to counter the attractive argument that if we could only rein in the profiteering scoundrels, our health care cost problems would be solved
  - Everyone has largely failed to grapple with the real drivers of health care costs

What Should Really Worry Producers?

(in addition to the general worries of the health insurance industry)

- How will transparency affect the business case for producer services in 2014 or before?
  - The federal web portal will include standardized benefits, quality and consumer satisfaction ratings, and premiums beginning in October. Same info will be provided by the state exchanges.
  - The Secretary will establish minimum benefits (covered services), assisting comparisons
  - Cost sharing will be expressed in standardized ways (bronze, …), assisting comparisons
  - There will be a uniform enrollment form
- Whose agent are you?
  - Classical problem of agency, similar to real estate agents and travel agents, whose business model has been drastically altered by transparency and the internet
  - How do carrier incentives influence recommendations (e.g., retention incentives)
  - Navigators will be agents of the exchange, required to give fair and impartial information, to educate, and to assist enrollment. Cannot be paid by carriers.
- What is your real value, to whom?
  - Carrier: Does the value change once information about benefits and prices becomes widespread and new routes to enrollment open (through the web or the Navigators)?
  - Exchange: What is the value of a Navigator?
  - Purchaser: If priced separately, would the value added match the price?

What Should Really Worry Health Plans?

- Relationships with both providers and subscribers are dominated by mistrust, and the traditional ally, purchasers, are more ambivalent
- Sympathizers are disillusioned with the capabilities of health plans to deal with the problems
  - Disappointment with the focus on driving down provider reimbursement and shifting costs
  - Growing belief that benefit design can't really rein in health care costs
  - Growing concern that CM / DM and QI can't be done effectively by plans
  - Even many strong proponents of competition believe that the market is deeply flawed and requires greater structure to facilitate meaningful competition – but competition among whom?
- The bill has features that require coordination among payers – and may favor evolution into a single payer system
  - This indirect approach runs a real risk that we will evolve into a single payer system without addressing the issues directly and designing ways to mitigate the adverse effects.

What Should Really Worry Health Plans?

- Strong interest in new payment methodologies and care delivery strategies that rely on provider organizations to control costs – ACOs, PCMHs, gain sharing reimbursement
  - So what do we need health plans for?
  - In fact, having multiple plans makes it difficult to craft and agree on effective incentives that apply across plans because of competitiveness, lack of flexibility, and antitrust concerns
  - Large, integrated health care delivery systems with an exclusive network of affiliated providers and gain sharing incentives may be more effective at quality improvement and cost control – but will they be physician centered or hospital centered?
  - Prediction: These large, dominant provider systems will have oligopoly and oligopsony power in many areas and may increase rather than decrease costs, leading to administered pricing of services.
- One proactive strategy will be for plans to play a more pivotal role in developing new payment methodologies - and in translating evidence into incentives acceptable to both patient and doctor.
  - These efforts will require agreement among plans – almost certainly under the aegis and oversight of government to minimize antitrust concerns